B6. Change in Cognitive Status (90 days ago)

Intent: To document changes in the resident's cognitive status, skills, or abilities as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). These can include, but are not limited to, changes in level of consciousness, cognitive skills for daily decision-making, short-term or long-term memory, thinking or awareness, or recall. Such changes may be permanent or temporary; their causes may be known (e.g., a new pain or psychotropic medication) or unknown. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Coding: Enter "**0**" for No change, "**1**" for Improved, or "**2**" for Deteriorated.

Examples of Change in Cognitive Status

Mrs. G experienced delirium (acute confusion) secondary to pneumonia approximately 30 days ago. With appropriate antibiotic therapy, hydration, and a quiet supportive milieu, she recovered. Although Mrs. G's cognitive skills did not increase beyond the level that existed prior to her pneumonia, and she remains unable to make daily decisions, she has steadily improved to her pre-pneumonia status. **Code "0" for No Change.**

Ms. P is intellectually intact. About two and one-half months ago she was informed by her daughter that her neighbor and lifelong friend had died while on a trip to Europe. Ms. P took the news very hard; she was stunned and seemed to be confused and bewildered for days. With support of family and staff, confusion passed. Although she continued to grieve, her cognitive status returned to what it was prior to her receiving the bad news. **Code "0" for No change.**

Mr. D was admitted to the nursing facility three months ago upon discharge from the hospital with signs of post-operative delirium. Since that time he no longer requires frequent reminders and re-orientation throughout each day. His decision-making skills have improved. **Code "1" for Improved**.

Mr. F has Alzheimer's disease. He did well until two months ago, when his primary nurse assistant reported that he could no longer find his way back to his room, which he was able to do three months ago. He often gets lost now while trying to find his way to the unit activity/dining room. **Code "2" for Deteriorated**.

Mrs. F was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long-term memory, and good recall abilities. Since that time, Mrs. F has had a stroke, which has left her with deficits in these areas. Within this Significant Change assessment period, her decisions have become poor. She is not aware of her new physical limitations and has taken unreasonable safety risks in transferring and locomotion. She receives supervision at all times. **Code "2" for Deteriorated**.

MDS Cognitive Performance Scale©

Many facilities have asked for a system to combine MDS cognitive items into an overall Cognitive Performance Scale. Such a scale has been produced: The MDS Cognitive Performance Scale (CPS)© **[see Appendix F]**. Five MDS items are used in assigning residents to one of seven CPS categories. The CPS categories are highly related to residents' average scores on the Folstein Mini-Mental Status Examination (MMSE), which has a score range of zero (worst) to thirty (best). According to Folstein, an MMSE score of 23 or lower usually suggests cognitive impairment but it may be lower for persons with an eighth grade education or less.

SECTION C. COMMUNICATION/HEARING PATTERNS

Intent: To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many possible causes for the communication problems experienced by elderly nursing facility residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

C1. Hearing (7-day look back)

Intent: To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the past 7-day period. Environmental adjustments include reducing noise volume by lowering the sound volume on televisions or radios, and installing amplification devices on televisions.

Process: Evaluate hearing ability after the resident has a hearing appliance in place, if the resident uses an appliance. Review the clinical record. Interview and observe the resident, and ask about the hearing function. Consult the resident's family, direct care staff, and speech or hearing specialists. Test the accuracy of your findings by observing the resident during your verbal interactions.

Be alert to what you have to do to communicate with the resident. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the resident needs to see your face to know what you are saying, or if you have to take the resident to a more quiet area to conduct the interview - all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, observe the resident interacting with others and while engaged in group activities. Ask the activities personnel how the resident hears during group leisure activities.

Coding: Enter one number that corresponds to the most correct response.

0. Hears Adequately - The resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.

1. Minimal Difficulty - The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.

2. Hears in Special Situations Only - Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible or requires the use of a hearing-enhanced telephone.

3. Highly Impaired/Absence of Useful Hearing - The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

C2. Communication Devices/Techniques (7-day look back)

Definition: **a. Hearing Aid, Present and Used** - A hearing aid or other assistive listening device is available to the resident and is used regularly.

b. Hearing Aid, Present and Not Used Regularly - A hearing aid or other assistive listening device is available to the resident and is not regularly used (e.g., resident has a hearing aid that is broken or is used only occasionally).

c. Other Receptive Communication Technique Used (e.g., lip reading) - A mechanism or process is used by the resident to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, writing by staff member, use of communication board).

d. ***NONE OF ABOVE***

Process: Consult with the resident and direct care staff. Observe the resident closely during your interaction.

Coding: Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check *NONE OF ABOVE*.

C3. Modes of Expression (7-day look back)

Intent: To record the types of communication techniques (verbal and non-verbal) used by the resident to make his or her needs and wishes known.

Definition: **a. Speech**

b. Writing Messages to Express or Clarify Needs - Resident writes notes to communicate with others.

c. American Sign Language or Braille

d. Signs/Gestures/Sounds - This category includes nonverbal expressions used by the resident to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for "yes" and once for "no" or squeezing another's hand in the same manner.
- Sounds may include grunting, banging, ringing a bell, etc.

e. Communication Board - An electronic, computerized or other homemade device used by the resident to convey verbal information, wishes, or commands to others.

f. Other - Examples include flash cards or various electronic assistive devices.

g. ***NONE OF ABOVE***

Process: Consult with the primary nurse assistant and other direct-care staff from all shifts, if possible. Consult with the resident's family. Interact with the resident and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations.

Coding: Check the boxes for each method used by the resident to communicate his or her needs. If the resident does not use any of the listed items, check *NONE OF ABOVE.*

C4. Making Self Understood (7-day look back)

Intent: To document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.

Process: Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary nurse assistant (over all shifts) if available, the resident's family, and speech-language pathologist.

Coding: Enter the number corresponding to the most correct response.

0. Understood - The resident expresses ideas clearly.

1. Usually Understood - The resident has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self understood.

2. Sometimes Understood - The resident has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

3. Rarely or Never Understood - At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

Clarification:

- A resident assessed in Item C4 (Making Self Understood) as "3" (Rarely/Never Understood), should not necessarily be coded as severely impaired in daily decision-making (Item B4, Cognitive Skills). The two areas of function are not always associated. The ability to understand may not be a functional problem, but a different language spoken by the resident. For example, a person who rarely/never understands may speak a language other than that spoken by caregivers, or he/she may be profoundly hearing or vision impaired. A more thorough assessment must be done to determine the actual level of cognitive function.

C5. Speech Clarity (7-day look back)

Intent: To document the quality of the resident's speech, not the content or appropriateness - just words spoken.

Definition: **Speech** - the expression of articulate words.

Process: Listen to the resident. Confer with primary assigned caregivers.

Coding: Enter the number corresponding to the most correct response.

0. Clear Speech - utters distinct, intelligible words.

1. Unclear Speech - utters slurred or mumbled words.

2. No Speech - absence of spoken words.

C6. Ability to Understand Others (7-day look back)

Intent: To describe the resident's ability to comprehend verbal information whether communicated to the resident orally, by writing, or in sign language or Braille. This item measures not only the resident's ability to hear messages but also to process and understand language. This may be due to functional problems or that the resident uses a different language.

Process: Interact with the resident. Consult with primary direct care staff (e.g., nurse assistants) over all shifts if possible, the resident's family, and speech-language pathologist. The resident may definitely be able to understand others when the information is presented to the resident in a way that he or she is most able to receive it. However, not all persons who interact with the resident will share information in the same way. If the resident needs to receive information in writing because he is highly hearing impaired but others (e.g., a roommate, visitors, other residents, etc.) do not present the information in writing, you must take this into consideration in coding the response that best reflects the resident's objective ability to understand information as it is presented to him.

Coding: Enter the number corresponding to the most appropriate response.

0. Understands - The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

1. Usually Understands - The resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.

2. **Sometimes Understands** - The resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When staff rephrases or simplifies the message(s) and/or use gestures, the resident's comprehension is enhanced.

3. **Rarely/Never Understands** - The resident demonstrates very limited ability to understand communication. Or, staff has difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

C7. Change in Communication/Hearing (90-days ago)

Intent: To document any change in the resident's ability to express, understand, or hear information compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: In addition to consulting primary care staff (over all shifts if possible), consulting the family of new admissions, and reviewing prior Quarterly assessment when available, ask the resident if he or she has noticed any changes in the ability to hear, talk, or understand others. Sometimes, residents do not complain of changes being experienced because they attribute them to "old age." Therefore, it is important that they be asked directly. Some types of deterioration are easily corrected (e.g., by new hearing aid batteries or removal of ear wax).

Coding: Enter the number corresponding to the most correct response. Enter "**0**" for No change, "**1**" for Improved, or "**2**" for Deteriorated.

Examples of Change in Communication/Hearing

Mrs. L has had expressive aphasia for two years. Although she periodically says a word or phrase that is understood by others, this is not new for her. During the last 90 days her communication status has essentially remained unchanged. **Code "0" for No change.**

Mrs. R's hearing is severely impaired. Five months ago the occupational therapist developed flash cards for staff to use when communicating with her. This was a tremendous boost for both Mrs. R and staff. Her ability to understand others continues to improve. **Code "1" for Improved.**

Upon admission two months ago Mrs. T had difficulty hearing unless the speaker adjusted his or her tone of voice and spoke more distinctly. She has worn hearing aids in the past but lost them during a hospital admission. Since admission to the nursing facility, Mrs. T was tested and fitted with new hearing aids. She hears much better with the aids though she is still trying to adjust to wearing them. **Code "1" for Improved.**

SECTION D.
VISION PATTERNS

Intent: To record the resident's visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used.

D1. Vision (7-day look back)

Intent: To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses, magnifying glass). It is not intended that the staff do an eye chart exam.

Definition: **"Adequate" Lighting** - What is sufficient or comfortable for a person with normal vision.

Process:

- Ask direct care staff over all shifts if possible, if the resident has manifested any change in usual vision patterns over the past seven days - e.g., is the resident still able to read newsprint, menus, greeting cards, etc.?

- Then ask the resident about his or her visual abilities.

- Test the accuracy of your findings by asking the resident to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.

- Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).

- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the resident has any visual ability.

- For residents who do not have the ability to see small objects and who are unable to participate in the eye testing described above, the assessor needs to conduct his or her own observation during the assessment process. Information may also be obtained by consulting with other staff that may be familiar with the resident's visual acuity.

Coding: Enter the number corresponding to the most correct response.

0. Adequate - The resident sees fine detail, including regular print in newspapers/books.

1. Impaired - The resident sees large print, but not regular print in newspapers/books.

2. Moderately Impaired - The resident has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3. Highly Impaired - The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).

Note: Many residents with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

4. Severely Impaired - The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

D2. Visual Limitations/Difficulties (7-day look back)

Intent: To document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurological diseases). It is important to identify whether or not these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

Process: **a. Side Vision Problems** - Observe the resident during his or her daily routine (e.g., eating meals, traveling down a hallway). Also, ask the resident about any vision problems (e.g., spilling food, bumping into objects and people). Ask the primary nurse assistant and other direct-care staff on each shift if possible, whether or not the resident appears to have difficulties related to decreased peripheral vision (e.g., leaves food on one side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).

b. Experiences Any of the Following - Ask the resident directly if he or she is seeing halos or rings around lights, flashes of light, floaters, or "curtains" over the eyes. Ask staff members if the resident complains about any of these problems.

c. ***NONE OF ABOVE***

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

D3. Visual Appliances (7-day look back)

Intent: To determine if the resident uses visual appliances regularly.

Definition: Glasses; contact lenses; magnifying glass - Includes any type of corrective device used at any time during the last seven days.

Coding: Enter "**1**" if the resident used glasses, contact lenses, or a magnifying glass during the past seven days. Enter "**0**" if none apply.

SECTION E.
MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to the nursing facility, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly nursing facility residents because they are very treatable.

In many facilities, staff has not received specific training in how to evaluate residents who have distressed mood or behavioral symptoms. Therefore, many problems are under diagnosed and under treated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities has found the various mental health RAPs (e.g., Mood, Behavior) to be helpful and these should be carefully reviewed.

The process for gathering information should include direct observation of the resident, communication with the resident's direct caregivers across all shifts, review of relevant information in the resident's clinical record and if possible, consultation with family members or friends who have a direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not observe the behavior but others report that it occurred, the behavior must be considered as having occurred and should be so documented. It is important to document chronic symptoms as well as new onset. As always, the medical record should support the resident's status as reported on the MDS.

It is important to note that coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E.; they simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators and consider them when developing the resident's care plan.

E1. Indicators of Depression, Anxiety, Sad Mood (30-day look back)

Intent: To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older nursing facility population. Rather, distress is more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. Resident Made Negative Statements - e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

b. Repetitive Questions - e.g., "Where do I go; What do I do?"

c. Repetitive Verbalizations - e.g., Calling out for help, ("God help me").

d. Persistent Anger with Self or Others - e.g., easily annoyed, anger at placement in nursing facility; anger at care received.

e. Self Deprecation - e.g., "I am nothing; I am of no use to anyone".

f. Expressions of What Appear to Be Unrealistic Fears - e.g., fear of being abandoned, left alone, being with others.

g. Recurrent Statements that Something Terrible is About to Happen - e.g., believes he or she is about to die, have a heart attack.

h. Repetitive Health Complaints - e.g., persistently seeks medical attention, obsessive concern with body functions.

i. Repetitive Anxious Complaints/Concerns (non-health related) - e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationship issues.

DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES:

SLEEP CYCLE ISSUES - Distress can also be manifested through disturbed sleep patterns.

j. Unpleasant Mood in Morning - e.g., angry, irritable.

k. Insomnia/Change in Usual Sleep Pattern - e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, Pained, Worried Facial Expressions - e.g., furrowed brows

m. Crying, Tearfulness

n. Repetitive Physical Movements - e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST - These items refer to a change in resident's usual pattern of behavior.

o. Withdrawal from Activities of Interest - e.g., no interest in long standing activities or being with family/friends. If the resident's withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the resident has withdrawn from activities of interest or has shown no interest in being with family/friends.

p. Reduced Social Interaction - e.g., less talkative, more isolated

Process: Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts, if possible, and family who have direct knowledge of the resident's behavior. Relevant information may also be found in the clinical record.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week (*i.e., exhibited at least once during the last 30 days but less than 6 days a week*)
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

Clarifications:

◆ The keys to obtaining, tracking and recording accurate information in Item E1, Indicators of Depression are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

- Daily communication between nurses, nurse assistants and other direct care providers is crucial for resident monitoring and care giving.

- Educate all caregivers (including direct care staff and staff who routinely come into contact with residents, such as housekeepers, maintenance, and dietary personnel about the residents' status in this area, and how to observe mood and behavior patterns that are captured in MDS Item E1. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated. Part of the reason may be that over time, these symptoms tend to be perceived as the residents' "normal" or "usual" behaviors.

- Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

◆ The mood items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether or not it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6 or 7 days a week), or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior occurred at least once, use code "1".

◆ If an indicator of depression occurs twice in the last 30 days (not 2 times each week), it should be coded as "1" to indicate that the indicator of depression was exhibited up to 5 days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the 30-day period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days.

Example

Mr. F is a new admission that becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He chastises her 'for not taking him into her home,' and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, tearful, and says "What's the use. I'm no good. I wish I died when my wife did." **Coding "1" for a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self deprecation), m. (Crying, tearfulness); remaining Mood items would be coded "0".**

E2. Mood Persistence (7-day look back)

Intent: To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console, or reassure the resident over the last seven days.

Process: Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding: Enter "**0**" if the resident did not exhibit any mood indicators over last seven days, "**1**" if indicators were present and easily altered by staff interactions with the resident or "**2**" if any indicator was present but not easily altered (e.g., behavior persisted despite staff efforts to console resident).

E3. Change in Mood (90 days ago)

Intent: To document change in the resident's mood as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: **Change in Mood** - Refers to status of any of the symptoms (new onset, improvement, worsening) described in Item E1 (verbal expressions of distress, sleep cycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and Item E2 (mood persistence). Such changes include:

- increased or decreased numbers of expressions or signs of distress
- increased or decreased frequency of distress occurrence

- increased or decreased intensity of expressions or signs of distress

Process: Review the clinical records including the last Quarterly assessment findings and transmittal records of newly admitted residents. Interview and observe the resident. Consult with staff from all shifts, if possible, to clarify your observations.

Coding: Code "**0**" if No Change, "**1**" if Improved, or "**2**" if Deteriorated as compared to status of 90 days ago.

Examples of Changes in Mood

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital for evaluation and treatment. Since her return to the nursing facility three weeks ago, her mood and appetite have improved while on a new lithium dose and an additional antidepressant drug. She is back to her "old self" of 90 days ago. **Code "0" for No change.**

During the admission assessment period of 90 days ago, Mr. M was tearful and expressed great sadness and anger over entering the nursing facility. He had difficulties falling asleep at night, was restless off and on during the night, and awakened too early in the morning, upset that he couldn't fall back to sleep. Since that time, Mr. M has been involved in a twice-weekly support group, and has been enjoying socializing in activities with new friends. He is currently sleeping through the night and feels well in the morning. Although he still expresses sadness and anger over his need for nursing facility care, it is less frequent and intense. **Code "1" for Improved**.

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was too restless. After the medication was discontinued, intensity of feelings and behaviors diminished and she has less frequent episodes of agitation. Mrs. D is better than she was, but she still has feelings of sadness. Mrs. D is now better than her worst status two months ago, but she has not fully recovered to her status of 90 days ago. **Code "2" for Deteriorated**.

During the admission assessment 6 weeks ago, Mrs. Z was very agitated. She had multiple daily complaints of vague aches and pains. She repetitively asked the nurses to "Call the doctor, I'm sick." After no physical problems could be identified, Mrs. Z was evaluated by a psychiatrist who diagnosed a clinical depression and prescribed an antidepressant drug. Its effect on Mrs. Z has been dramatic. During this Significant Change assessment, Mrs. Z had many fewer complaints about her health and was more involved in unit activities. **Code "1" for Improved.**

E4. Behavioral Symptoms (7-day look back)

Intent: To identify **(A)** the **frequency**, and **(B)** the **alterability** of behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others on the unit. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused.").

Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provide a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the resident's current status may not initially be detailed (and in some cases will not pinpoint the resident's actual problems) and it is not intended to be the one and only source of information. (See Process below) However, once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

Definition:

a. Wandering - Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item E1n, "Repetitive physical movements."

b. Verbally Abusive Behavioral Symptoms - Other residents or staff were threatened, screamed at, or cursed at.

c. Physically Abusive Behavioral Symptoms - Other residents or staff were hit, shoved, scratched, or sexually abused.

d. Socially Inappropriate/Disruptive Behavioral Symptoms - Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. Resists Care - Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has

exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff has become used to the behavior and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptom or not? Is the resident combative during personal care and strike out at staff or not?

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff that provides direct care on all three shifts. A symptomatic behavior can be present and the RN Assessment Coordinator might not see it because it occurs during intimate care on another shift. Therefore, it is especially important that input from all nurse assistants having contact with the resident be solicited.

Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behavior over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

Coding: ## (A) Behavioral Symptom Frequency in Last 7 Days.

Record the frequency of behavioral symptoms manifested by the resident across all three shifts.

Code "0" if the behavioral symptom described was not exhibited in the last seven days.

Code "0" for each type of behavior described in Item E4, if the resident did not exhibit that type of symptom in the last seven days. This code applies to residents who have never exhibited the behavioral symptom or those who have

previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program. For example: A "wandering" resident who did not wander in the last seven days because he was restricted to a geri-chair would be coded "0" - Behavioral symptom not exhibited in last seven days. The questionable clinical practice of restricting wandering by placing a person in a geri-chair to restrict movement would then be evaluated using the Physical Restraints RAP.

Code "1" if the described behavioral symptom occurred 1 to 3 days, in last 7 days.

Code "2" if the described behavioral symptom occurred 4 to 6 days, but less than daily.

Code "3" if the described behavioral symptom occurred daily or more frequently (i.e., multiple times each day).

(B) Behavioral Symptom Alterability in Last 7 Days.

Code "0" if either the behavioral symptom was not present or the behavioral symptom was easily altered with current interventions.

Code "1" if the described behavioral symptom occurred with a degree of intensity that is not responsive to staff attempts to reduce the behavioral symptom through limit setting, diversion, adapting unit routines to the resident's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc. For example: A cognitively impaired resident who hits staff during morning care and swears at staff with each physical contact on multiple occasions per day, and the behavior is not easily altered, would be coded "1".

Examples for Wandering	(A) Frequency	(B) Alterability
Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behavior is easily channeled into other activities when staff redirects Ms. T by inviting her to activities. Ms. T is easily engaged and is content to stay and participate in whatever is going on.	3	0

Examples for Wandering (continued)	(A) Frequency	(B) Alterability
Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been met with Mr. W hitting and pushing staff. Over time, staff has found him to be most content while he is wandering within a structured setting.	3	1

E5. Change in Behavioral Symptoms (90 days ago)

Intent: To document if the behavioral symptoms or resistance to care exhibited by the resident remains stable, increased or decreased in frequency of occurrence or alterability as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). Consider changes in any area, including (but not limited to) wandering, symptoms of verbal or physical abuse or aggressiveness, socially inappropriate behavior, or resistance to care. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: **Change in Behavioral Symptoms** - refers to the status (new onset, improvement, worsening) of any of the symptoms described in Item E4 (Behavioral Symptoms). Such changes include:

- increased or decreased **numbers** of behavioral symptoms,
- increased or decreased **frequency** of behavioral symptoms occurrence,
- increased or decreased **intensity** of behavioral symptoms,
- increased or decreased **alterability** of behavioral symptoms.

Process: Review nursing notes and resident's records, including the last Quarterly assessment findings and transmittal records of newly admitted residents. Observe the resident. Consult with direct care staff across all shifts, if possible, and family to clarify your observations.

Coding: **Code "0"** if no change has occurred in behavioral symptoms. This code should also be used for the resident who has no behavioral symptoms currently or 90 days ago.

Code "1" (Improved) if the behavioral symptoms became fewer, less frequent, less intense, and were not complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

Code "2" (Deteriorated) if the behavioral symptoms became more frequent, more intense or were complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

Examples of Change in Behavioral Symptoms

Despite staff efforts to provide support and structure over the last 90 days, Mrs. H continues to hoard food in her room every day. Staff understands the needs of this formerly homeless woman, but because they have found ants and cockroaches in her room, they feel a need to reevaluate their approach to care. **Code "0" for No change since last assessment.**

During the seven-day assessment period, Mrs. D had a difficult time with bowel regularity. She had a history of constipation that became worse during an episode of pneumonia and poor fluid intake that resulted in dehydration. During this time Mrs. D was more confused and subdued. On several occasions during the assessment period She was found disimpacting herself and smearing feces (Socially Inappropriate/Disruptive Behavior). Upon examination, Mrs. D was found to have a fecal impaction. She received treatment and was placed on a bowel regimen. The program was successful in eliminating the socially inappropriate behavioral symptoms that were induced by discomfort. However, once Mrs. D started to feel better and was more alert, she resumed her former daily wandering (of 4 months ago), pushing others and rummaging through their dresser drawers. **Code "0" for No change since last assessment.**

Mrs. F has always been a quiet passive woman who has never exhibited any behavioral symptoms since her admission to the nursing facility. During this Significant Change assessment following Mrs. F's stroke, no problematic behavioral symptoms were noted. **Code "0" for No change since last assessment.**

Mr. C wanders in and out of other residents' rooms and rummages through their belongings at least once a day and sometimes more often. Despite this behavior, during the last few weeks, he has been easier to work with now that he is more familiar with staff. Although wandering and rummaging continue, he no longer screams, curses, and shoves residents and staff who try to stop this behavior as he did 90 days ago. **Code "1" for Improved.**

Ninety days ago Mrs. R banged her cane loudly and repetitively on the dining/activity room table about once a week. In the past week, staff has noticed that this socially inappropriate behavioral symptom (disruptive sounds) now occurs multiple times daily. **Code "2" for Deteriorated.**

SECTION F.
PSYCHOSOCIAL WELL-BEING

Intent: To determine the resident's emotional adjustment to the nursing facility, including his or her general attitude, adaptation to surroundings, and change in relationship patterns.

F1. Sense of Initiative/Involvement (7-day look back)

Intent: To assess the degree to which the resident is involved in the life of the nursing facility and takes initiative in participating in various social and recreational programs, including solitary pursuits.

Definitions:

a. At Ease Interacting with Others - Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents, staff, and visitors. A resident who tries to shield himself or herself from being with others, spends most time alone, or becomes agitated when visited, is not "at ease interacting with others."

b. At Ease Doing Planned or Structured Activities - Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is at ease doing planned or structured activities, or a resident who pursues activity programs, seems content to be involved, and takes initiative in participating. A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses to attend any such activities, is not "at ease doing planned or structured activities."

c. At Ease Doing Self-Initiated Activities - These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., folding personal laundry, organizing belongings). Such residents find things to do to occupy themselves, like reading, writing letters or making phone calls. A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to find something for him or her to do, is not "at ease doing self-initiated activities." For these residents, there is no element of self-direction or self-initiation in activity involvement.

d. Establishes Own Goals - Consider statements the resident makes, such as "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. However, some goals may not actually be verbalized by the resident, but inferred in that the resident is observed to have an individual

way of living at the facility (e.g., organizing own activities or setting own pace).

e. Pursues Involvement in Life of Facility - In general, consider whether or not the resident partakes of facility events, socializes with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the nursing facility or the particular nursing unit is "involved in the life of the facility."

f. Accepts Invitations into Most Group Activities - A resident who is willing to try group activities even if later deciding the activity is not suitable and leaving, or who does not regularly refuse to attend group programs, "accepts invitations into most group activities."

g. ***NONE OF ABOVE***

Process: Selected responses should be confirmed by objective observation of the resident's behavior (either verbal or nonverbal) in a variety of settings (e.g., in own room, in unit dining room, in activities room) and situations (e.g., alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident. Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations. Then talk with staff members who have regular contact with the resident (e.g., nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember, it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Cognitively impaired residents may show signs of being at ease by smiling, making eye contact with the activity leader, actively participating in the activity (clapping, tapping, dancing) and if not actively participating, the resident may be sitting or standing quietly during the activity. A cognitively impaired resident who is not at ease during an activity may cry or call out during the activity, repeatedly try to get up to leave the activity and not respond to gentle cueing to return to the activity, shout or strike out at staff or other residents. Use your best clinical judgment as a basis for planning care. If the resident is not at ease interacting with others and/or doing planned or structured activities, it should be coded regardless of the suspected reason and regardless of whether or not this is the resident's normal status. Continue to code this item if the problem persists over time.

Coding: Check all that apply. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply. If you do not check any items in Section F1, check *NONE OF ABOVE*. For individualized care planning purposes, remember that information conveyed by unchecked items is no less important than information conveyed by checked items.

Clarification:

- Item F1d, "Establishes own goals" and F3a, "Strong identification with past roles and life status" trigger the Psychosocial RAP. Both trigger elements were added in response to providers and consumer advocacy groups' desires to use the triggers to help staff focus on areas of resident strengths. This helps in staffs' efforts to assist the resident to reach his or her highest practicable level of well-being. Data indicated that triggers needed to be more inclusive for this RAP.

F2. Unsettled Relationships (7-day look back)

Intent: To indicate the quality and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff members, family, and other residents).

Definition:

a. Covert/Open Conflict with or Repeated Criticism of Staff - The resident chronically complains about some staff members to other staff members, verbally criticizes staff members in therapeutic group situations causing disruption within the group, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any assumption about why the problem exists or how it might be remedied.

b. Unhappy with Roommate - This category also includes "bathroom mate" for residents who share a private bathroom. Unhappiness may be manifested by frequent requests for roommate changes, or grumbling about "bathroom mate" spending too long in the bathroom, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioral status of roommate. Other examples of roommate compatibility issues include early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spending too much time on the telephone, or snoring, or odors from incontinence or poor hygiene.

c. Unhappy with Residents Other Than Roommate - May be manifested by chronic complaints about the behaviors of others, poor quality of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., repetitive, ongoing complaints beyond a reasonable level).

d. Openly Expresses Conflict/Anger with Family/Friends - Includes expressions of feelings of abandonment, ungratefulness on part of family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

e. Absence of Personal Contact with Family/Friends - Absence of visitors or telephone calls from others in the last seven days.

f. Recent Loss of Close Family Member/Friend - Includes relocation of family member/friend to a more distant location, even temporarily (e.g., for the winter months), incapacitation or death of a significant other, or a significant relationship that recently ceased (e.g., a favorite nurse assistant transferred to work on another unit).

g. Does Not Adjust Easily to Change in Routines - Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g., staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

Example

For the past 6 months, Mrs. A has been receiving 2 white pills, 1 blue pill, 1 yellow pill and 2 puffs of medication from an orange hand-held aerosol inhaler. The drug company that makes the inhaler recently changed its packaging. When Mrs. G is given the new blue inhaler to use and is told that it is the same drug with a different color holder, she becomes very agitated and upset. It takes a lot of patience and reassurance by the nurse before Mrs. G uses the new inhaler. This happened for several days during the past week. Based on this example, the clinician would check Item F2g, "does not adjust easily to change in routines."

Process: Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about?

It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last seven days?

During routine nursing care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with direct-care staff (e.g., nurse assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the evaluator, you are seeking to gain an overall picture, a consensus view.

Coding: Check all that apply over the last seven days. If none apply, check *NONE OF ABOVE.*